

**Office of the Inspector General for Mental Health,  
Mental Retardation and Substance Abuse Services**

**Commonwealth Center for Children and Adolescents  
Staunton, Virginia  
Inspection**

**James W. Stewart, III / Inspector General**

**OIG Report #145-07**

Issued February 6, 2008

An inspection was conducted at the Commonwealth Center for Children and Adolescents (CCCA) in Staunton, Virginia on June 30, 2007. Follow-up visits to the Center occurred on October 24, 2007 and December 6, 2007. The primary focus for this inspection was a review of the active findings and recommendations from OIG Report#131-06, which for this facility included the following:

- The facility's use of prone facedown restraint, and
- The completion of a study to determine the appropriate capacity and staffing complement based on the facility's changing utilization patterns.

Other areas of focus for this inspection included the facility's overall staffing patterns and active treatment initiatives.

Interviews were conducted with 36 members of the staff including administrative, clinical, and direct care staff. OIG staff viewed the facility informational DVD. A tour of the facility was conducted. Documentation reviews included:

- Four clinical records
- Proposed new employee orientation and staff training curricula
- Facility data relevant to the use of seclusion and restraint, staff injuries, utilization reviews, and staff turnover, and
- Stakeholder Workgroup Report on State Bed Use

## **SECTION I – INTRODUCTION**

CCCA is the only facility operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) that is dedicated solely to the care and treatment of children and adolescents. This 48-bed freestanding facility is located in Staunton and has been in operation at its current site (adjacent to Western State Hospital) since 1996. Many of the facility's support functions such as, food service, security, laundry, and facility/ground maintenance are provided by Western State Hospital.

CCCA serves children and adolescents ages 4 through 17. The facility's service area includes all 40 community services boards across the Commonwealth, except adolescents

13 years and older from Health Planning Region III, who are served by Southwestern Virginia Mental Health Institute (SWVMHI). Individuals admitted to the facility have a primary diagnosis of mental illness. Approximately 65% of adolescents served have co-occurring mental health and substance use disorder (MH/SA) diagnoses. A majority of the children and adolescents admitted also have significant behavior problems. On the initial day of the inspection, the facility had a census of 29. This included 8 children between the ages of 8 and 12 and 21 adolescents over age twelve.

There were 558 admissions and 561 discharges at CCCA during FY07. This represents a 7% increase in admissions over FY06. The increase in admissions was attributed to limited community resources for dealing with children and adolescents during the acute phase of their illnesses, more diagnostically complicated cases, and an increased scrutiny of and decreased tolerance for challenging behaviors and symptoms following the tragedy at Virginia Tech.

The facility works with the referring community services boards to determine whether an alternative plan to avoid hospitalization can be developed. Multiple factors are considered at the time of admission including:

- The person's history in treatment, including current clinical presentation,
- The lethality and risks associated with the person's symptoms,
- The family's capacity for coping with the situation, and
- The community's capacity to safely serve the individual in an alternate setting

The chart below provides information regarding the utilization of the facility over the last five fiscal years:

<b>CCCA UTILIZATION DATA FOR FY03 THROUGH FY07</b>					
	<b>FY03</b>	<b>FY04</b>	<b>FY05</b>	<b>FY06</b>	<b>FY07</b>
Number of Admissions	486	479	537	521	558
Number of Discharges	481	491	538	510	561
Number of Readmissions Within 30 days	28	42	40	45	42
Average Daily Census	35.2	33.4	29	31.5	34.3
Average LOS (days)	27	27.6	19.6	22.2	22.7
Median LOS (days)	19	15	13	15	14
% Bed Occupancy	73%	70%	60%	66%	71%
Cost Per Bed Day	\$725.53	\$776.06	\$943.46	\$920.16	\$914.92

Source: CCCA Utilization Management Database

There are 140 approved full-time employee positions or MEL (maximum employee levels) at CCCA. As of July 1, 2007, 131 or 94% of the positions were filled. Of the 131 positions, 78 or 60% were direct services classifications, including 64 direct care associate positions and 14 nursing positions; 29 or 22% were clinical positions and; 24 or 18% were administrative and support positions.

## **SECTION II - NEW INITIATIVES IN FY2007**

Through interviews with staff at all levels, the OIG identified the following new initiatives at the facility during FY2007:

### **New Employee Orientation**

At the time of the inspection, CCCA was in the process of revising the new employee orientation program with a goal of providing staff with a working knowledge of administrative and clinical practices, how their role(s) and duties fit within the services provided, and with a basic understanding of overall performance expectations.

The workgroup designated to oversee the development of this initiative includes a variety of clinical and supervisory staff. In collaboration with the facility's leadership team, this workgroup established principles to govern not only this initiative, but to link ongoing clinical skill development training opportunities with the facility's mission, values and philosophy of treatment. The governing principles as described to OIG staff are as follows:

- All behavior happens for a reason.
- It is the duty of all staff to understand the reasons for the behavior. By working together staff are to support, shape, and assist each individual in making changes that will improve his or her quality of life.
- The essential function of the staff at the facility is to understand, not control. The most significant agent of change is the quality of the relationship each staff member has with the individuals who are supported.

The majority of staff interviewed by the OIG made positive remarks about the orientation revision process. They indicated that they were pleased that the workgroup leaders had solicited ideas and observations from across the disciplines and had taken into account the varying educational backgrounds, work experience, and life skills of new employees. Supervisory and direct care staff stated that the increased emphasis on clinical skill building from the onset, coupled with enhanced mentoring and supervision, would assist new employees in performing their duties and facilitate effective service provision.

### **Initiatives to Reduce the Use of Seclusion and Restraint**

The reduction of seclusion and restraint (SR) has been an expressed goal of the facility for a number of years. The facility created or enhanced a number of initiatives in FY07 to aid in this effort including:

- Developing a workgroup, consisting of members of direct care, nursing, and psychology staffs, to review the facility's use of the point system because of its potential for being more punitive than instructive.
- During the first quarter of CY07, the facility launched an incentive program designed to foster the use of alternative, less restrictive interventions. Each unit that experiences a decrease in the use of restrictive interventions across all three shifts for a set period of time receives a pizza party. In April 2007, Unit 2 was the first to achieve this goal.

- Applying for and being accepted as one of two state-operated facilities to share a \$213,702 grant from SAMHSA to develop alternatives to restraint and seclusion usage. The duration of the grant is up to three years.
- In an updated status report regarding the use of SR at CCCA, dated September 2007, DMHMRSAS reported that “in the coming months, the Center will employ independent evaluators to review leadership’s commitment to SR reduction; the impact of reduction SR on the treatment environment; clinical treatment activities; and how effectively clinical policies, procedures and practices support the mission, vision, and values of the DMHMRSAS. Concurrent with this assessment, the Center will assess its training curricula and teaching practices to identify improved training delivery strategies. These activities will serve as the basis for a strategic plan to implement evidence-based interventions to reduce the use of seclusion and restraint.”

### **Informational Video**

Administrative and clinical staff recognized that parents are often very concerned and can be both alarmed and confused when inpatient treatment is recommended. As a result, CCCA, in conjunction with James Madison University, created an informational video for families that highlights the facility. In the approximately 20 minute video, the facility is viewed through the eyes of a parent and includes general information about the services provided and what prospective admissions and their families might expect from the treatment process.

The facility received a grant to defray the costs of duplicating the DVD, including the addition of English and Spanish subtitles. CCCA plans to distribute the DVD to the community services boards for use during their admission prescreening process, as appropriate.

## **SECTION III - FINDINGS**

**Finding 1: CCCA continues to have a very high number of behavioral management incidents that result in the use of seclusion and restraint. The majority of these incidents (62%) occur during the evening shift. The facility has been unable to sustain any significant reduction in the incidents of seclusion and restraint over the past five years.**

- The OIG first identified concerns about CCCA seclusion and restraint practices in 1999.
- Following is the pattern of incidents of seclusion over the past five years:
  - FY04 – 725
  - FY05 – 316
  - FY06 – 794
  - FY07 – 735
  - FY08 (first quarter) – 163

- The majority of seclusion events (76%) occur on Unit 1 and Unit 2, which typically provide services for the younger children.

<b>Frequency of Seclusion Use By Unit for FY2007</b>													
	<b>July 06</b>	<b>Aug 06</b>	<b>Sept 06</b>	<b>Oct 06</b>	<b>Nov 06</b>	<b>Dec 06</b>	<b>Jan 07</b>	<b>Feb 07</b>	<b>Mar 07</b>	<b>Apr 07</b>	<b>May 07</b>	<b>June 07</b>	<b>Total</b>
Unit 1 (Children)	7	14	22	17	19	8	19	15	17	17	12	14	181
Unit 2 (Children)	25	22	16	34	50	42	41	37	33	9	37	32	378
Unit 3 (Adolescent)	12	3	16	11	9	7	7	11	17	8	9	7	117
Unit 4 (Adolescent)	0	0	1	1	5	5	11	7	9	10	2	8	59
<b>Total</b>	<b>44</b>	<b>39</b>	<b>55</b>	<b>63</b>	<b>83</b>	<b>62</b>	<b>78</b>	<b>70</b>	<b>76</b>	<b>44</b>	<b>60</b>	<b>61</b>	<b>735</b>

Source: CCCA Seclusion and Behavioral Restraint Database

- Following is the pattern of incidents of emergency mechanical restraint over the past five years:
  - FY04 – 130
  - FY05 - 127
  - FY06 – 175
  - FY07 – 179
  - FY08 (first quarter) – 36
- The majority of emergency mechanical restraint usage occurs on the Unit 3 and Unit 4 that typically provide services for adolescents.

<b>Frequency of Emergency Mechanical Restraint Use By Unit for FY2007</b>													
	<b>July 06</b>	<b>Aug 06</b>	<b>Sept 06</b>	<b>Oct 06</b>	<b>Nov 06</b>	<b>Dec 06</b>	<b>Jan 07</b>	<b>Feb 07</b>	<b>Mar 07</b>	<b>Apr 07</b>	<b>May 07</b>	<b>June 07</b>	<b>Total</b>
Unit 1 (Children)	0	2	3	4	2	5	1	2	4	3	0	1	27
Unit 2 (Children)	5	4	0	6	1	0	0	0	4	0	0	1	21
Unit 3 (Adolescent)	6	2	0	0	0	7	7	4	5	4	15	15	65
Unit 4 (Adolescent)	1	0	0	1	4	7	11	6	6	10	9	11	66
<b>Total</b>	<b>12</b>	<b>8</b>	<b>3</b>	<b>11</b>	<b>7</b>	<b>19</b>	<b>19</b>	<b>12</b>	<b>19</b>	<b>17</b>	<b>24</b>	<b>28</b>	<b>179</b>

Source: CCCA Seclusion and Behavioral Restraint Database

- A significant majority of the incidents of seclusion and restraint (62%) occur during the evening shift. This is true for each type of incident – seclusion (61%), physical restraint (64%) and mechanical restraint (66%).

<b>CCCA Incidents of Seclusion &amp; Restraint by Shift FY2007</b>							
	<b>Day</b>	<b>% Day</b>	<b>Evening</b>	<b>% Evening</b>	<b>Night</b>	<b>% Night</b>	<b>Total</b>
Seclusion	263	36%	447	61%	25	3%	735
Physical Restraint	27	30%	57	64%	5	6%	89
Mechanical Restraint	48	27%	119	66%	12	7%	179
<b>Total</b>	<b>338</b>	<b>34%</b>	<b>623</b>	<b>62%</b>	<b>42</b>	<b>4%</b>	<b>1003</b>

Source: DMHMRSAS Seclusion and Behavioral Restraint Reports

- The percentage of incidents of seclusion and restraint that occurred during the evening shift at CCCA in FY2007 (62%) was significantly higher than on other shifts. The chart below compares CCCA incidents of seclusion and restraint by shift to the SWVMHI adolescent unit.

<b>Facility Comparison of Incidents of Seclusion &amp; Restraint by Shift FY2007</b>							
<b>Facility</b>	<b>Total Incidents of S&amp;R</b>	<b>Day Total</b>	<b>Day %</b>	<b>Evening Total</b>	<b>Evening %</b>	<b>Night Total</b>	<b>Night %</b>
CCCA	1003	338	34%	623	62%	42	4%
SWVMHI (Adolescent)	192	104	54%	80	42%	8	4%

Source: DMHMRSAS Seclusion and Behavioral Restraint Reports

- Supervisory staff reported that seclusion and restraint are the most frequently used techniques at CCCA when the persons served become violent toward themselves or others. They stated that this occurs for the following reasons:
  - The high turnover in direct care staff requires the facility to constantly educate and support new inexperienced staff in understanding and adapting to the demands of the environment and the behaviors demonstrated by many of the persons served.
  - Physical interventions and confinement such as restraint and seclusion are often inexperienced staff's first and most natural response to challenging behaviors.
- The number of incidents of all forms of seclusion and restraint per 10 residents based on the FY2007 average daily census (ADC) at CCCA was 295. This is more than the Adolescent Unit at SWVMHI (240) and 11.5 times the average of 25.5 incidents of seclusion and restraint per 10 residents for seven of the eight mental health facilities/units that serve adults (Eastern State Hospital data not available).

<b>FY07 Incidents of Seclusion &amp; Restraint per 10 Residents for DMHMRSAS Operated MH Facilities</b>				
<b>Child Adolescent Facilities/ Units</b>	<b>Total Incidents of S&amp;R</b>	<b>FY07 ADC</b>	<b>Ratio per 10 residents</b>	<b>Incidents of S&amp;R per 10 residents</b>
CCCA	1003	34	3.4	295.0
SWVMHI	192	8	0.8	240.0
<b>Adult MH Facilities/ Units</b>				
CSH	1635	240	24	68.1
WSH	963	241	24.1	40.0
SWVMHI	406	143	14.3	28.4
NVMHI	211	122	12.2	17.3
SVMHI	72	69	6.9	10.4
CAT	103	107	10.7	9.6
PGH	0	120	12	0
ESH	NA	427	42.7	NA

Source: DMHMRSAS Seclusion and Behavioral Restraint Reports

- Administrative staff at CCCA state that the use of restrictive techniques within the facility is higher than desired, however they maintain that its use has been relatively stable over the past few years except for FY05 and not out of line with other facilities.
- Even though all the staff interviewed endorsed the goals of reducing seclusion and restraint, the majority of direct care (75%) and the majority of administrative and clinical staff interviewed (60%) reported facility safety would be compromised if the use of seclusion and restraint was eliminated. This suggests that staff at CCCA do not have an understanding of alternative intervention techniques for preventing and managing behavioral incidents.

**Finding 2: CCCA continues to utilize prone restraints. The incidence of utilizing prone restraints is very high.**

- As a result of the spring 2006 inspection at CCCA, the OIG recommended in Report #131-06 that the DMHMRSAS Office of Quality Management review the use of prone restraints at CCCA and actively monitor the facility's efforts at reducing the use of restrictive procedures.
- The facility initiated the collection of data on the use of prone restraints in February 2007. According to the CCCA risk manager, from February 1 through December 31, 2007 there were 560 restraint incidents that were initiated with a physical hold. Of this total, 165 or 29% involved the use of floor prone restraint.

<b>Use of Prone Restraints by Month</b>			
<b>CY 2007 Month</b>	<b>Total number of physical restraints</b>	<b>Total number of prone physical restraints</b>	<b>% of physical restraints that are prone</b>
February	37	17	46%
March	40	16	40%
April	31	8	26%
May	56	25	45%
June	32	13	41%
July	36	18	50%
August	42	19	45%
September	87	17	20%
October	48	9	18%
November	46	3	7%
December	105	20	19%
11 Month Total	560	165	29%

Source: CCCA Risk Management Database

- TOVA (Therapeutic Options of Virginia) allows for the limited use of prone restraint when a child falls to the ground from a sitting or standing restraint position. The training advises staff to support the person during the fall to minimize injuries, but to return the person to a sitting or standing restraint as soon as possible.
- SWVMHI, the only other DMHMRSAS operated mental health facility that serves adolescents, has a policy of not using prone restraints with residents.
- Because of its potential for resulting in serious injury and death, prone restraints have been banned in at least 3 states (Maryland, California and Pennsylvania) and eliminated through policy initiatives in others, including Ohio and New York. In talking with representatives from Ohio, New York, and Maryland, OIG staff learned that one of the most important factors that enabled significant reductions in the use of seclusion and restraint in those states was a strong commitment by the organizations' leaders to create a nonviolent environment that actively supports the elimination of restrictive procedures.
- In interviews with the OIG inspectors, the CCCA director and clinical director maintained that if properly used, prone restraint is no more dangerous than other forms of restraint. When asked about the utilization rate for this technique during the last five months of 2007, they said they had been surprised at how high the utilization actually was.

**Finding 3: CCCA program managers and clinical staff are not certified to provide behavioral management techniques. As a result, direct care staff do not receive appropriate support and supervision for the use of these techniques; senior staff are not qualified to physically intervene when incidents occur that require behavioral management intervention; and the credibility and acceptance of senior staff as leaders and teachers is reduced.**

- Administrative staff confirmed that clinical staff are not trained in TOVA (Therapeutic Option of Virginia) or expected to intervene during behavioral emergencies.

- CORE standards require that all staff members that have direct contact with residents are to be trained in behavioral management. The behavior management model endorsed by DMHMRSAS is TOVA. This training provides staff with the necessary knowledge and skills to safely support consumers during acts of physical aggression or extreme behavioral incidents.
- The direct care and supervisory staff who were interviewed expressed the opinion that the burden on direct care staff of implementing seclusion and restraint procedures and injuries often associated with these procedures would be significantly reduced if more staff were trained in TOVA.
- Administrative and supervisory staff informed the OIG that when TOVA was first introduced at the facility all the staff having direct contact with the consumers had been required to complete the training. However, recertification has not occurred since then for many, if not all, of the clinical staff.
- Administrative staff acknowledged that the fact that clinical staff are not trained in TOVA or expected to intervene during behavioral emergencies plays a significant role in direct care staffs' beliefs about workplace safety since they are the only ones asked to place themselves at risk when dealing with residents during severe behavioral incidents.
- Direct care and supervisory staff indicated that not having all staff trained to intervene during emergency situations is inconsistent with the treatment philosophy endorsed by the leadership team regarding staff working together as a team, supporting one another.

**Finding 4: The majority of direct care staff frequently do not feel safe performing their duties at the facility. The incidence of injury to direct staff is very high.**

- The majority (80%) of the direct care staff reported that they frequently do not feel safe in performing their duties in the facility. These staff described experiencing a high incidence of both primary trauma (managing aggressive behaviors with subsequent injuries) and secondary trauma (verbal abuse, threats of harm) in their work environment.
- There were 205 reported staff injuries needing medical intervention during FY07; 202 of the injuries were sustained by direct care staff, and 3 injuries involved nursing staff. Of these injuries, 91% occurred during incidents of seclusion, restraint and/or aggressive acts by the children.
- The number of staff injuries per 10 residents based on the FY2007 average daily census (ADC) at CCCA was 60.3 in FY2007. This is just less than the Adolescent Unit at SWVMHI (63.8) and 7.5 times the average of 8.0 injuries per 10 residents for the other eight mental health facilities.

<b>FY07 Injuries per 10 Residents for DMHMRSAS Operated MH Facilities</b>				
<b>Child Adolescent Facilities/ Units</b>	<b>Total Injuries to Staff</b>	<b>FY07 ADC</b>	<b>Ratio per 10 residents</b>	<b>Injuries per 10 residents</b>
SWVMHI	51	8	0.8	63.8
CCCA	205	34	3.4	60.3
<b>All MH Facilities</b>				
CCCA	205	34	3.4	60.3
SWVMHI	157	143	14.3	11.0
CAT	93	107	10.7	8.7
NVMHI	106	122	12.2	8.7
WSH	197	241	24.1	8.2
CSH	194	240	24	8.1
PGH	75	120	12	6.3
SVMHI	36	69	6.9	5.2
ESH	213	427	42.7	5.0

Source: Monthly reports submitted to the OIG by the DMHMRSAS operated facilities.

- Supervisory staff reported at the time of the initial visit that 16 members of the direct care staff were on light duty status because of work related injuries, further decreasing the number of trained personnel that were available to assist in implementing a seclusion or restraint procedure. This results in trained staff having to be pulled from other units within the facility when assisting with restraint procedures, significantly changing the staff to patient ratios on the other units, which in their opinion is a risky practice.
- Interviews with direct care staff revealed that ongoing concerns regarding personal safety is one of the primary reasons their peers seek employment outside the facility.
- Members of the leadership team reported that even though the facility serves persons identified as a danger to themselves or others and many of the persons admitted engage in seriously dangerous behaviors, the environment is essentially safe because of (1) the structure and support that is in place, (2) the behavioral management techniques used by staff to interact with the consumers, and (3) the many clinical review processes that are utilized.

**Finding 5: The rate of staff turnover, which continues to be extremely high at CCCA, is a destabilizing factor for the facility.**

- Twenty-seven of the 37 employees leaving the Center (73%) in FY07 were in direct care classifications (24 DSA II and 3 DSA III)<sup>1</sup>. For DSA II positions the rate was 53%. The DSA classifications comprise the largest number of employees within the facility, and the individuals serving in these positions have the most contact with the persons receiving services.
- The turnover rate for nurses in FY2007 was 36%. Five full time nurses left employment during the past fiscal year. Three of the five nurses (60%) left in less than one year of their hiring.
- During FY07, there were 24 DSA II separations and 24 new hires. Of the 24 new DSAII hires, 6 (25%) left in less than a year requiring that the position be refilled within the same fiscal year.
- The average turnover rate for DSA II positions for the past ten years, based on MEL is 59.5%, ranging from 37.5% to 93.5%.
- Nearly half of the employees who left CCCA in FY07 had less than a year's tenure with the organization:
  - Eleven of the 24 DSA II employees left within a year (46%)
  - Three of the DSA II's left within six months (12.5%).
- The chart below shows the turnover rate for direct care associates over the past ten years.

<b>CCCA Turnover Rate for DSA II Positions (Direct Service Associate) During FY98 through FY07</b>										
	<b>FY98</b>	<b>FY99</b>	<b>FY00</b>	<b>FY01</b>	<b>FY02</b>	<b>FY03</b>	<b>FY04</b>	<b>FY05</b>	<b>FY06</b>	<b>FY07</b>
Authorized DSA II (MEL)	40	40	46	46	46	46	46	45	45	45
# DSA II Hired	24	23	44	36	24	32	47	28	23	24
# DSA II Left Employment	15	19	28	32	27	25	43	29	25	24
% DSA II (MEL) Turnover	<b>37.5%</b>	<b>47.5%</b>	<b>61%</b>	<b>69.5%</b>	<b>59%</b>	<b>54%</b>	<b>93.5%</b>	<b>64.5%</b>	<b>55.5%</b>	<b>53%</b>

Source: Facility Employee Demographics and Staff Turnover Report

<sup>1</sup> The staff turnover data contained in this report was obtained from the facility report entitled the Report of Employee Demographics and Staff Turnover at the Commonwealth Center for Children and Adolescents for FY2007, by David Colton, Ph.D.

- The following chart shows that the turnover rate at CCCA for DSA I and II positions in FY2007 was significantly higher than other DMHMRSAS mental health facilities. The next highest was Catawba Hospital at 46.9%. The turnover rate at CCCA was about twice the rate at Western State Hospital located on the same campus. Both of these facilities hire from the same communities.

<b>FY07 Turnover of Direct Care Staff in DMHMRSAS Operated Mental Health Facilities</b>			
DSAs I & II			
Facility	Average Filled	Separations	Turnover %
CCCA	43.5	25	57.5%
CAT	72.5	34	46.9%
NVMHI	75	29	38.7%
WSH	195	66	33.8%
ESH	318.5	70	22.0%
SWVMHI	176	33	18.8%
PGH	90	14	15.6%
SVMHI	45	6	13.3%
CSH	4	0	0.0%

Source: DMHMRSAS Central Office Human Resource Management Data FY2007

- Supervisory staff indicated that direct care staff safety concerns often result in staff feeling angry, helpless, and demoralized. Supervisors reported that the following factors contribute to direct care staff “burn out” and turnover:
  - Inconsistency in practices across the treatment teams and among the program managers
  - The varying levels of leaders within the organization often endorsing different treatment approaches
  - Each team functioning autonomously, often creating different expectations within the facility, which results in staff confusion regarding performance expectations
  - The mixing of very different populations on a single unit (forensic and civil) which often results in (1) part of the group being kept on the unit when others are allowed to go on outings and (2) outings not to occur because there is not enough staff to supervise unit residents in two separate settings at the same time. Both cause residents to act out and demonstrate inappropriate behavior.
- Fourteen (14) staff members who were interviewed conveyed to the inspectors that it is their belief that the very high rate of turnover that has continued for so many years has been accepted by leadership as an organizational norm instead of being viewed as a potential indicator of other organizational stressors.
- Administrators offered the following explanations for the ongoing high rate of staff turnover:

- It is not uncommon for individuals, particularly those with a bachelor's degree, to remain at the facility for up to two years while either continuing their education or gaining the skills necessary for becoming more competitive in their chosen fields.
- The facility is often unable to sustain a competitive edge after the initial years of training since entry level positions in other mental health programs in the area offer a better pay structure, few or no requirements for working nights or weekends, and offer positions in which employees are exposed to less risk for harm.

**Finding 6: Communication within the facility is ineffective. A significant result of this is that direct care staff do not understand the strategies adopted by senior management for reducing seclusion and restraint, decreasing staff turnover, and increasing workplace safety.**

- Direct care staff were successful in articulating the leadership team's vision for reducing seclusion and restraint, decreasing staff turnover, and increasing workplace safety, but were not able to describe the strategies adopted by the leadership of the facility or actions taken by senior managers to address these issues.
- Numerous staff at direct care and supervisory levels reported to the OIG that they receive unclear and inconsistent direction from the various members of the CCCA senior management team. As a result they do not understand what senior leaders expect of them.
- Most middle managers reported to the OIG that the members of the senior management team often communicate inconsistent messages and direction to staff. They also observed that communication from the senior management team is not open enough to enable staff to understand the basis for expectations.
- Many supervisory and middle management staff observed that CCCA operates very much in silos that fosters division and limits communication across the organizational units and treatment teams.
- Some members of the senior management team also identified ineffective communications as an organizational issue. Even though those interviewed indicated efforts to address this on all levels have been underway over the past year, they acknowledged that more work was needed. The efforts cited included:
  - Increasing direct care staff involvement in the overall decision-making process in the facility
  - Increasing support for the supervisory staff and building their competence in coaching, mentoring, and supporting the work of the individuals they oversee.
  - Creating an employee mentor position so that staff can share concerns confidentially and ask for assistance in developing strategies for dealing with workplace stress.
- A number of middle managers reported to the OIG that the members of the senior management team have difficulty managing conflict and often avoid it. When conflicts arise, this at times results in failed initiatives.

- The supervisory and middle management staff observed that while the senior management team includes caring, compassionate and experienced individuals, they would be more effective as a group if they were better able to manage conflict and modeled more open communication within the facility.

The Office of the Inspector General is very concerned about the lack of progress at CCCA in addressing the high incidence of seclusion and restraint and alarmed by the use of prone restraints. The OIG is also very concerned about the high incidence of staff injury and the high rate of staff turnover at the facility. The inspectors who conducted the site visits at CCCA in June, October and December 2007 believe that the following are significant contributing factors to this lack of progress:

- Despite a growing national consensus that the use of prone restraint is dangerous and re-traumatizing for staff and residents, the senior management team continues to maintain that if properly used it is no more dangerous than other forms of restraint.
- Despite the fact that staff injuries are high, management continues to describe the environment as safe because certain practices are promoted.
- Despite the fact that personal safety and the high incidence of staff injury is cited as the second most common reason individuals seek employment elsewhere, management maintains that it is expected that staff will leave the facility after a short stay during which they develop skills because they are better educated than most and want more for themselves.

## SECTION IV- RECOMMENDATIONS

**Recommendation 1:** It is recommended that DMHMRSAS establish an Advisory/Oversight Committee composed of experts in the establishment of non-violent treatment environments, DMHMRSAS central office representatives and representatives from other DMHMRSAS facilities by no later than February 27, 2008. The responsibility of the committee will be to:

- Identify the factors which have contributed to the high number of incidents of behavioral management that have resulted in the use of seclusion and restraint and particularly prone restraint,
- Identify the factors which have contributed to the high number of incidents of staff injury,
- Identify the factors which have contributed to the extremely high rate of staff turnover.

And to make recommendations for changes in facility culture, organization, policy, procedures and practice that will:

- Dramatically reduce the incidents of seclusion and restraint and sustain the reduction over time,
- Eliminate the practice of prone restraint within nine months,
- Decrease staff injuries significantly
- Decrease staff turnover significantly.

Progress reports should be provided to the OIG every six months beginning July 1, 2008.

***DMHMRSAS Response:*** *At the December 4, 2007 Facility Directors' meeting the Office of Quality Management and facility directors established a Seclusion and Restraint Workgroup. The first meeting is scheduled for February 2008. This Workgroup is being established as a subcommittee of the Clinical Services Quality Management Committee and will serve as the Advisory/Oversight Committee identified in Recommendation #1. The goal of this Workgroup is to develop and implement plans to dramatically reduce the use of seclusion and restraint and to be able to sustain this reduction over time.*

*Five facility directors will serve on the workgroup including: Dale Woods, EdD, SWVTC; Charles Davis, MD, CSH; Lynn Delacy, RN, PhD, NVMHI; Joe Tuell, RN, CCCA; and Denise Micheletti, RN, CVTC. Central Office representatives will include Marion Greenfield, Office of Quality Management; Priscilla Scherger, Office of Facility Operations and Quality Improvement; Carolyn Lankford, Office of Quality Management; Mary Clair O'Hara, Office of Quality Management; Miranda Turner, Office of Risk Management; and a representative of the Office of Human Resource Management.*

*Additional members will include consultants with expertise in the establishment of non-violent treatment environments and others currently invited. The Workgroup will address the need for additional subcommittees as well as linkages with other, existing committees currently studying related issues (e.g., staff turnover) at the first meeting.*

*The Workgroup will meet at least quarterly and report to the Clinical Services Quality Management Committee. A report of the workgroup's progress will be submitted to the Commissioner, the Director of Health and Quality Care, and the Inspector General semi- annually.*

*The facility directors identified the following priorities for the seclusion and restraint workgroup:*

- Evaluate the relationship between the age of the workforce, seclusion and restraint use, and injuries.*
- Evaluate the impact of staff vacancies, staff turnover, and the use of locum tenens on seclusion and restraint use and injuries.*
- Identify and develop profiles of individuals frequently placed in seclusion and restraint.*
- Evaluate the relationship between admissions and client/resident mix on seclusion and restraint use.*
- Evaluate the effectiveness of current training programs on seclusion and restraint use.*

*The Workgroup will address the additional priorities identified in the Inspector General's recommendations regarding CCCA, including:*

- *Examination of the factors which have contributed to the high number of incidents of behavioral management that have resulted in the use of seclusion and restraints and particularly prone restraint.*
- *Identification of the factors which have contributed to the high number of incidents of staff injury.*
- *Identification of the factors which have contributed to the extremely high rate of staff turnover.*
- *The elimination of use of prone restraint by November 2008.*

*The Workgroup will, for each of the established priorities:*

- *Develop plans and strategies to reduce the use of seclusion and restraints.*
- *Prepare recommendations for the Commissioner for new and revised policies and procedures, training programs, resource allocation, and other actions deemed necessary to reduce seclusion and restraints.*
- *Identify, test, and disseminate effective strategies for reducing and sustaining reductions in seclusion and restraint use.*
- *Evaluate the impact of all seclusion and restraint reduction efforts relative to staff injuries, staff turnover, and other relevant variables.*

**Recommendation 2:** It is recommended that CCCA train and certify all clinical, supervisory and direct care staff in TOVA techniques and assure that all remain certified.

***DMHMRSAS Response:*** *The Leadership Team at CCCA agrees that all staff who have contact with children must be trained and certified in TOVA and that they will maintain re-certification annually. This includes clinical and administrative employees as well as supervisory and direct care staff who lack this certification and have contact with children. Beginning Monday February 4, 2008, a monthly series of two-day TOVA trainings will begin for CCCA staff members who currently do not have certification. The two-day training in TOVA philosophy and intervention techniques will be held each month in conjunction with new staff orientation. All non-certified CCCA staff will sign up to receive training in TOVA between February 4, 2008 and May 25, 2008 during the monthly new staff orientations. All staff in the above positions will receive their initial certification in TOVA by the end of May 2008. The Leadership Team at CCCA will conduct monthly reviews of TOVA training to monitor the progress of all staff in obtaining training and certification as required and develop alternative trainings as needed.*

## **SECTION V - STATUS OF OUTSTANDING FINDINGS AND RECOMMENDATIONS**

### **OIG Report #56-02 (March 2002) and OIG Report #131-06 (May 2006)**

**Finding 3.2** (OIG Report #56-02): The observed use of restraints was inconsistent with the current D.I. recommendations that restraints either be utilized for acute emergency management or as a formalized part of an approved behavioral management program.

**Recommendation** (OIG Report #56-02): Reconcile the existing the Departmental Instruction on Seclusion and Restraint with practice at CCCA. Consider consultation on particularly challenging individuals with in-state resources such as behavioral consultation teams in place at other facilities.

The OIG's annual follow-up review of the above finding 3.2 regarding the facility's use of seclusion and restraint in May 2006 resulted in the following additional OIG recommendation:

**Recommendation** (OIG Report #131-06): It is recommended that the CO Office of Quality Management review the use of prone restraints at CCCA and actively monitor the facility's efforts at reducing the use of restrictive procedures.

**Status of Recommendations** (#3.2 OIG Report #56-02 and OIG Report #131-06): These recommendations have been replaced by recommendations related to seclusion and restraint in OIG Report #145-07 and therefore have been determined by the OIG to be **INACTIVE** effective January 2008.

### **OIG Report # 109-05 (December 2004)**

**Finding #1:** Over the past several years, there have been significant changes in the facility's utilization patterns:

- The number of admissions annually increased 8.6% over 10 years from 441 (FY 95) to 479 (FY 04).
- The average length of stay (ALOS) decreased 33% over 10 years from 41.2 (FY 95) to 27.6 (FY 04).
- In 2004, the facility was able to prevent state hospitalization of 50% of the requests for admission (503 of 1002 requests) because applicants had private insurance, applicants did not meet acute hospitalization criteria, or bed space could be located in the community.

As a result:

- The annual average daily census (ADC) dropped 24.4% over 10 years from 45 (FY 95) to 34 (FY 04).
- The ADC dropped 27% over the past 5 years from 37 (FY 01) to 27 (first 9 months of FY 05).

- With an average ADC of 33.8 over the past 5 years, the facility has operated at 70.4% of its 48 bed capacity from FY 01 through the first nine months of FY 05.
- The number of days in which the census exceeded 75% of capacity dropped from 43.8% in FY 03 to 9.15% in the first nine months of FY 05.
- The current staffing ratios when calculated against the ADC of 33.8 over the past 5 years reveal the following:

	Current Complement	Staff to Consumer
Psychiatrist	4	1 to 8.5
Psychologist	5	1 to 6.76
Social Worker	10	1 to 3.38
Activity Therapist	4	1 to 8.5
Nurse Manager	3	1 to 11.4

- The cost per bed day as reported by the facility is \$1,019. This is the highest daily cost of all 16 facilities operated directly by DMHMRSAS.

Two of the major factors that have enabled this significant decrease in the utilization of CCCA include effective diversion to community alternatives and successful utilization management by the facility.

**OIG Recommendation:** It is recommended that DMHMRSAS and CCCA conduct a study with the involvement of a broad range of stakeholders to determine:

- The appropriate capacity for CCCA in order to serve the needs of the most seriously emotionally disturbed children and adolescents in the Commonwealth who cannot be served in less restrictive settings
- The appropriate staffing complement to support this capacity
- The financial resources required to operate the facility at this capacity
- What portion, if any, of the resources currently deployed to CCCA could be more effectively utilized to address the needs of seriously emotionally disturbed children and adolescents with the goal of providing services closer to home in less restrictive and less costly settings.

**OIG Progress Review June 2007:** In January 2006, a DMHMRSAS CO Workgroup met to organize a response to the OIG recommendation outlined in Report #109-05 (Finding #1). This workgroup formulated a set of 10 questions designed to address the key elements in the recommendation. Upon completing this task, the workgroup requested the Child and Family Behavioral Policy and Planning Committee call together members of the Child and Adolescent Special Populations Workgroup to form a subcommittee to respond to each of the questions.

The 23 member subcommittee was established in February 2006. The group met on four occasions between February and May 2006. The subcommittee presented its final report on State Facility Bed Use for Children and Adolescents to members of the DMHMRSAS Workgroup, the DMHMRSAS Office of Child and Family Services, and the Child and Family Behavioral Health Policy and Planning Committee in November 2006.

**Status of Recommendation:** (#1 OIG Report #109-05): This recommendation is determined by the OIG to be **INACTIVE** effective January 2008.